CLAIM FOR SERVICES FURNISHED

State Form 32 (R9 / 11-99) / OMPP 0175
Approved by Auditor of State 1999
Approved by State Board of Accounts 1999

VENDOR: Your Social Security number or Federal Identification number is required in order for payment to be issued for this claim.
Social Security number or Federal Identification number

VENDOR IDENTIFICATION
Name of vendor (first, middle, last)
Address (number and street, city, state, ZIP code)

CASE NUMBER		
Type	County code	Serial number
Patient's county of residence		Diagnosis
Name of attending physician		Purpose of claimed services ☐ Diagnosis ☐ Treatment

COMPLETE THIS SECTION FOR MEDICAL ASSISTANCE DISABILITY DETERMINATION CLAIM		
Application date (month, day, year)	Name of patient (last, first, middle)	Patient's Social Security number

DATE OF SERVICE MO.	DAY	YR.	DESCRIPTION OF SERVICES PERFORMED (Please itemize)	CHARGES	REJECTION OR REDUCTION CODE

TOTAL CHARGES	
Enter any amount paid on above by or on behalf of patient.	
TOTAL AMOUNT CLAIMED	

VENDOR CERTIFICATION	
I hereby certify that the foregoing account is just and correct, that the amount claimed is legally due, after allowing all just credit, and that no part of the same has been paid.	
Signature of vendor or authorized agent	Billing date

PATIENT CERTIFICATION (OPTIONAL)	
Signature of patient	Date

COUNTY CERTIFICATION (OPTIONAL)	
Signature of director	Date

EXPLANATION OF REJECTION / REDUCTION CODES

01 - Charge exceeds the allowed payment for an examination including report.
02 - Charge exceeds allowed payment for a report.
03 - Charge exceeds the allowed payment for copies of records.
04 - Examination performed prior to the application date. Reimbursement can only be made for the supplied report.
05 - Service listed is not related to the Medicaid disability determination process. Please refile your claim with the appropriate service code if applicable to this program.
06 - Treatment charges are not allowed as part of the Medicaid disability determination process.
07 - This service was not authorized by the Medicaid Medical Review Team physician. Payment can not be made.
08 - Claim for services rendered should be submitted to the Medicaid claims processing contractor for payment.
09 - Charge exceeds the allowed payment for this test.
10 - Other

MEDICAID DISABILITY EXAMINATION FEE SCHEDULE

Physical Examination - $65
Psychological Evaluation - $80 / hour (maximum 90 minutes)
IQ Testing - $80 / hour (maximum two hours)
Copies of Records - $10
Letter or Report - $10
Eye Examination - $29
Visual Field Testing - $36.64

All other testing and specialty evaluations will be reimbursed according to the Medicaid fee-for-service schedule in effect on the date of service for the CPT procedure code authorized by the Medicaid Medical Review Team.

DISTRIBUTION: Vendor - Retain 4th copy. Send first 3 copies to the County Office of the Division of Family and Children as soon as services heve been rendered.

COUNTY OFFICE, DFC - retain 3rd copy and insert into case record. Send first two copies to the OMPP / MRT.